Increasing safety for youth in and leaving foster care

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Topics

- Introduction
- Impact of maltreatment
- Use of psychotropic medications
- Suicidality among youth
- Commercially sexually exploited children (CSEC) and foster care
- Recommendations

Impact of maltreatment

- 40%-60% of maltreated children have mental health problems (Linares et al, 2013).
- Self-regulation
  - Executive functioning
  - Managing strong feelings and impulses
- Social-emotional processing
  - Compromised interpersonal relationships

Dysregulated stress response system

- Trained at biological level to be on alert
- Can’t turn off trauma-induced activation of stress response system
- Once adaptive and protective
- Now maladaptive and can increase dangers

Impact on development over time

- Influence on brain, social, and identity development going forward
- Compounded by broken or disturbed attachments
- Unresolved trauma and unresolved grief add to internal burden, creating risks from others and from the self.

Poor mental health presents risks to safety

- Contributes to:
  - to school failure
  - Unemployment
  - Poverty
  - Early parenthood
  - Lack of medical treatment
  - Homelessness
  - Victimization and exploitation
  - Suicide
  - Violence to others

Psychotropic medication and children in foster care

- Use of mental health services 15-20 times that of children in general population (Wolff et al, 2013)
- 40%-60% meet criteria for at least one psychiatric disorder (Wolff et al, 2013)
- By adolescence, 63% have at least one diagnosis; 23% have three or more. (White et al, 2007)
- Psychotropic meds: 13%-40%, compared with 4%-6% in general population. (Wolff et al, 2013; Lyons et al, 2013; Burcu et al, 2013)

- Polypharmacy (multiple medications concurrently) – children in care take greater average number of medications Lyons et al, 2013)
- More frequently prescribed antipsychotics, especially for ADHD, than general population. (Linares, 2013)
- Nearly 9 times rate of Medicaid-enrolled children not in care (USDHHS, 2012)

Which children?

- Those in most restrictive placement settings
- White males
- Males with behavior problems
- Use and use of multiples higher among 6- to 10-year-olds than 11- to 17-year-olds
- Those **under 1 year** have 0.3%-2/1%, compared with 0.1%-1.2% of those not in care. (USDHHS, 2012)

Safety risks in adolescence: suicidality

- Youth in child welfare and juvenile justice systems 3-5 times more likely to die by suicide (National Center for Prevention of Youth Suicide, 2013).
- Children and youth in care at greater risk of suicide and attempting suicide (Katz et al, 2011)
- Trauma involving assaultive violence and child sexual abuse predicts suicidal behavior.
- Depressive symptoms play major role.

Suicidality: which youth?

- Deaths: males
  - 10-14 yrs: 3.8 to 1
  - 15-19 yrs: 4.7 to 1
  - 20-24 yrs: 6.7 to 1.
- Attempts: females more frequent in teen years
- Those with foster care histories 4 times more likely to report suicidal ideation.
- Homelessness and child sexual abuse increase risk (Corbett et al, 2012)
- Among maltreated 8-yr-olds: 10% reported wanting to kill themselves.

Safety risks in adolescence: sex trafficking

- 50% of those sold into trafficking in CA and 85% in NY have child welfare
- Among survivors of trafficking, 98% had cw involvement
- High rates of sexual assault in childhood.
- Recruited at younger ages
- Male, female, ethnically diverse, LGBT (Lillie, 2013; Spangenberg, 2001)

Sex Trafficking and Homelessness

- 22% of youth aging out become homeless
- 75% of all victims were at one point homeless
- 1 in 3 homeless teens lured into CSE within 48 hours.
- Recruited youth have aged out, run away, or been lured away from home.

Recommendation #1

- **Use of psychotropic medications should be carefully considered and based on screening, assessment, and treatment planning.**
  - Consider availability of nonpharmacological interventions
  - Weigh risks and benefits of psychotropics in children
  - Use should always entail effective medication monitoring, and informed, shared decision-making and ongoing communication.
  - Mental health experts, including board certified psychiatrists, should provide consultation when establishing processes of consent and monitoring.

Recommendation #2

- **Screenings** (for depression, for trauma and status of trauma resolution, for cognitive, behavioral, emotional, and social development relative to normative development) should take place **prior to entry into care, at entry, at regular intervals, during transition planning, and at exit from care.**

Recommendation #3

- **When psychotherapy is indicated, tailor treatment to individual youth rather than disorder.**
  - Consider symptoms, strengths, vulnerabilities, culture, history, developmental status, current situation/environment, available treatments, evidence of effectiveness.
  - Consider gender, ethnicity, and culture
  - Address trauma- and attachment-related issues.

Recommendation #4

- Ensure the **maximum placement stability** and, with cooperation from school districts, **school stability, especially during middle school (a time of high sensitivity to changes in environment)** and high school.

Recommendation #5

- Begin **planning for post-secondary education or career training** during middle school.
  - Monitor educational progress toward goals at regular intervals.
- **Academic achievement is a protective factor**, building self-esteem, positive identity, and future employment potential.
  - Attendance at 4-year college prevents homelessness.

Recommendation #6

- **Sex trafficking prevention**:
  - **Document** nature and extent of problem in LA County
  - **Increase awareness** of problem
  - **Train law enforcement and social workers** to recognize possible indicators.
  - **Involve youth as partners** in developing policies, programs, and resources.

Recommendation #7

- **Transition planning with youth**:
  - Careful assessment of availability of **caring others and social support network, including cultural and spiritual dimensions**
  - Remediation of gaps prior to exit.
  - **Network assessment should include biological and extended family** (potential sources of strength, but often continuing stressors and risks to fragile well-being.
  - Provide services aimed at ameliorating family relationships prior to exit from care.

Recommendation # 8

- **Build in safeguards against homelessness** following discharge from care
  - Onsite visits to planned living arrangement.
  - No discharge without certainty of housing.
  - Monitoring of housing stability for the year (or more) following discharge.

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